U.S. Department of Labor

Office of Administrative Law Judges
Seven Parkway Center - Room 290
Pittsburgh, PA 15220

(412) 644-5754
(412) 644-5005 (FAX)

Issue Date: 25 July 2006

CASE NO.: 2005-BLA-5503

In the Matter of

RONALD McCRAE,
Claimant

v.

EIGHTY-FOUR MINING COMPANY,
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

APPEARANCES:

Ron Carson, Lay Representative[1]
Lynda D. Glagola, Lay Representative[2]
For the Claimant

George H. Thompson, Esquire
For the Employer

Before: RICHARD A. MORGAN
Administrative Law Judge

DECISION AND ORDER-DENYING BENEFITS

This proceeding arises from a claim for benefits filed by Ronald McCrae, a former coal miner, under the Black Lung Benefits Act, 30 U.S.C. §901, *et seq*. Regulations implementing the Act have been published by the Secretary of Labor in Title 20 of the Code of Federal Regulations.[3]

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[1] Ron Carson is the Black Lung Program Director at Stone Mountain Health Services in St. Charles, Virginia (TR 4).
[2] Lynda D. Glagola is the Program Director at the Lungs at Work clinic in McMurray, Pennsylvania (TR 5).
[3] The Secretary of Labor adopted amendments to the "Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969" as set forth in Federal Register/Vol. 65, No. 245 Wednesday, December 20, 2000. The revised

Black lung benefits are awarded to coal miners who are totally disabled by pneumoconiosis caused by inhalation of harmful dust in the course of coal mine employment and to the surviving dependents of coal miners whose death was caused by pneumoconiosis. Coal workers' pneumoconiosis is commonly known as black lung disease.

A formal hearing was held before the undersigned on December 6, 2005, in Pittsburgh, Pennsylvania. At that time, all parties were afforded full opportunity present evidence and argument as provided in the Act and the regulations issued. Furthermore, the record was held open for the submission of post-hearing evidence and briefs (TR 51-52). The Employer's post-hearing submissions were filed under cover letters, dated December 21, 2005, December 30, 2005, January 25, 2006, and February 22, 2006, respectively. The documents submitted have been marked and received in evidence as Employer's Exhibits 8 through 13 (EX 8-13). The Claimant's post-hearing submissions were filed under cover letter, dated February 24, 2006. The documented submitted have been marked and received in evidence as Claimant's Exhibits 7 through 9 (CX 7-9). As set forth in my Order Granting Extension of Time for Filing Closing Briefs, dated March 8, 2006, the deadline for submission of closing briefs was extended to a postmark date of March 31, 2006. The letter briefs filed on behalf of Claimant and Employer, respectively, were timely filed.

The record consists of the hearing transcript, Director's Exhibits 1 through 43 (DX 1-43), Claimant's Exhibits 1 through 9 (CX 1-9), and Employer's Exhibits 1 through 13 (EX 1-13).

The findings of fact and conclusions of law which follow are based upon my analysis of the entire record, including all documentary evidence admitted, testimony presented, and arguments made. Where pertinent, I have made credibility determinations concerning the evidence.

Procedural History

On November 21, 2003, Claimant, Ronald McCrae, filed the current application for black lung benefits under the Act (DX 3).[4] On October 15, 2004, the District Director issued a Proposed Decision and Order awarding benefits (DX 36). Following Employer's timely request for a formal hearing (DX 37), this matter was referred to the Office of Administrative Law Judges for adjudication (DX 41-43). As previously stated, a formal hearing was held on December 6, 2005, and the record was held open for the submission of post-hearing evidence and closing arguments.

Issues

I. Whether the miner has pneumoconiosis as defined by the Act and the regulations?

Part 718 regulations became effective on January 19, 2001. Since the current claim was filed on November 21, 2003 (DX 3), the new regulations are applicable (DX 43).

[4] On the same date that Claimant filed a proper application for Federal black lung benefits on a U.S. Department of Labor form (DX 3), he also filed a similar application on a Social Security Administration form (DX 2). The use of the Social Security Administration application form was erroneous and redundant.

II. Whether the miner's pneumoconiosis arose out of coal mine employment?
III. Whether the miner is totally disabled?
IV. Whether the miner's disability is due to pneumoconiosis?

(DX 41; TR 6-7).

Findings of Fact and Conclusions of Law

I. Background

A. Coal Miner and Length of Coal Mine Employment

Claimant has alleged that he engaged in coal mine employment for 23 years (DX 3; TR 16). The parties stipulated, and I find, that Claimant engaged in coal mine employment for 19.99 years (DX 8; TR 6-7). Moreover, I find that this discrepancy is inconsequential for the purpose of rendering a decision herein.

B. Date of Filing

Claimant filed the current claim for benefits under the Act on November 21, 2003 (DX 3). Employer stipulated, and I find, that the claim for benefits is timely filed (TR 6).

C. Responsible Operator

Employer, Eighty-Four Mining Company, is the properly designated responsible operator in this case, under Subpart G of the Regulations (DX 7; TR 16-17).

D. Personal, Employment, and Smoking History

Claimant, Ronald McCrae, was born on December 8, 1940. He has one dependent for the purpose of possible augmentation of benefits under the Act; namely, his wife, Paula McCrae (DX 3, 10, 11). Claimant has established 19.99 years of coal mine employment.

Claimant testified that he left the coal mines on September 22, 1995. His last usual coal mine job was as an inside utility man (TR 17). The job entailed physical exertion, including loading and lifting various coal mine-related supplies, such as bolts, rock dust bags, and mortar mix, as well as shoveling. It also entailed a considerable amount of standing, walking, and bending, as well as occasional climbing (TR 17-21). Furthermore, throughout Claimant's coal mine employment he worked in underground mines, where he was exposed to coal mine dust (DX 5; TR 18, 21-25). Claimant is currently employed as a "part-time" driver for Meals on Wheels (TR 28). He drives a van approximately five or six hours per day, five days per week, and delivers meals to various centers (TR 35-36). However, I find that the exertional requirements of Claimant's current job are not comparable to those entailed in his last usual coal mine job as an inside utility man. Furthermore, Claimant stated that he could not return to his usual coal mine job because he can't breathe underground anymore, and he tires easily and can't walk very far (TR 28-29).

Claimant provided somewhat conflicting statements regarding the reason for leaving the coal mines. He initially testified that that he stopped working in 1995, "because I noticed I was having trouble breathing" (TR 25). Subsequently, Claimant testified that he left the coal mines because he was injured in a mining accident, when a piece of slate fell and hit him on the head (TR 26, 32).

Claimant testified that he first noticed that he was having a breathing problem in 1992 or 1993 (TR 25-26). Claimant stated that he has been treated by Dr. Celko for his breathing condition since 1995 (TR 26, 33-34). Claimant testified that he had been taking Albuterol and Advair for at least two years, but he switched to Spiriva pills about nine months prior to the hearing (TR 27-28, 33). Claimant is also treated by Dr. Mitchell, who told him not to run or job due to a back injury. However, Claimant has never complained to Dr. Mitchell about breathing problems, because "he's not that type of a doctor." (TR 34-35). Claimant also testified that he has been treated by Dr. Bobak, but Claimant doesn't complain to him about breathing problems for the same reason (TR 43-44). Claimant was treated at Mercy Hospital in April 2005, where Dr. Generalovich inserted a stent (TR 42).

Claimant acknowledged that he has a long cigarette smoking history. Furthermore, Claimant conceded that he has provided inconsistent smoking histories to various physicians (TR 37-41). Claimant also provided conflicting testimony at the formal hearing regarding his smoking history. For example, Claimant stated: "I've been smoking ever since, I guess, about a year after I got out of the service, which would have been '63" (*i.e.,* age 23). (TR 37). Moreover, Claimant initially testified that he smoked 2 – 2 ½ packs "when I was in the service," but subsequently stated: "I mean, after I got out of the service…when I was on construction, operating heavy equipment." (TR 39). However, Claimant also testified that he actually started smoking when he was nine years old, as reported by Dr. Celko (TR 39-40; *see also* DX 15). Claimant also stated that he told various physicians that he smoked either 1 or 1 ½ packs per day, and, that if any of the physicians reported more than 1 ½ pack per day, it was because "I made the mistake" (TR 38). In fact, Dr. Cohen reported that Claimant had smoked up to 2 packs per day before cutting back to ½ pack per day (CX 1), and Dr. Fino reported that Claimant smoked 2 to 2 ½ packs per day for 31 years before reducing his smoking habit to ½ pack per day (EX 1). Finally, the record contains the following exchange regarding Claimant's current smoking status:

Q. Are you smoking today?
A. Do I still smoke today?
Q. Yes.
A. I quit about - - maybe about two months ago.
Q. Totally?
A. Trying to, yes, sir.

(TR 39). I find no reason for Claimant to have exaggerated his actual cigarette smoking history, but that he may have felt it was in his self-interest to understate it, in conjunction with his claim for black lung benefits. Accordingly, I find that Claimant has smoked from age 9 (*i.e.,* 1949)

until October 2005.[5] Moreover, I find that Claimant has smoked an average of 1 to 2 packs per day. Taken as whole, I find that Claimant has a 56 to 112-pack cigarette smoking history.

II. Medical Evidence

The medical evidence includes various chest x-rays, pulmonary function studies, arterial blood gases, and physicians' opinions, which are summarized below.

A. Chest X-rays

The case file contains various interpretations of chest x-rays, dated February 2, 2004 (DX 18/19, DX 21, DX 22/EX 2; CX 5), August 31, 2004 (CX 3; EX 1), January 25, 2005 (CX 1, 8; EX 10), September 14, 2005 (CX 2, 9; EX 8), and November 7, 2005 (CX 7; EX 7), respectively.

Of the foregoing, the following are positive for pneumoconiosis under the classification requirements set forth in §718.102(b): Dr. Cohen's interpretation of the x-ray dated January 25, 2005 (CX 1); and, Dr. Gohel's multiple interpretations of x-rays dated February 2, 2004 (CX 5), August 31, 2004 (CX 3), September 14, 2005 (CX 2, 9), and November 7, 2005 (CX 7). Drs. Cohen and Gohel are both B-readers. Moreover, Dr. Gohel is a dual-qualified B-reader and Board-certified radiologist (CX 1, 2).

On the other hand, the record also includes the following negative interpretations under the classification requirements set forth in §718.102(b): the reading by Drs. Thomeier of the February 2, 2004 film (DX 19/20); Dr. Fino's interpretation of the August 31, 2004 x-ray (EX 1); the multiple readings by Dr. Hayes of x-rays dated February 2, 2004 (DX 22/EX 2), January 25, 2005 (EX 10), and September 14, 2005 (EX 8), and the interpretations by Drs. Pickerill and Abrahams of the November 7, 2005 x-ray (EX 7). Drs. Thomeier, Fino, Hayes, Pickerill, and Abrahams are all B-readers. Furthermore, Drs. Thomeier and Hayes are dual-qualified B-readers and Board-certified radiologists (DX 20, 22).[6]

In summary, the record contains multiple positive and negative interpretations by similarly well-qualified B-readers and/or Board-certified radiologists. Accordingly, I find that the x-ray evidence neither precludes nor establishes the presence of pneumoconiosis.

B. Pulmonary Function Studies

A claimant must show he is totally disabled and that his total pulmonary disability is caused by pneumoconiosis. The regulations set forth criteria to be used to determine the

[5] Claimant's testimony suggests that he may not have completely stopped smoking even after October 2005, despite his effort to do so (TR 39). Moreover, when Dr. Bobak testified at deposition on February 8, 2006, he stated that he thought that Claimant still smokes (EX 12, p. 44).

[6] The record also contains an interpretation by Dr. Navani, a B-reader and Board-certified radiologist, of the chest x-ray dated February 2, 2004. However, Dr. Navani's reading is for quality purposes only. He reported a film quality of "2" (*i.e.,* "Acceptable with no technical defect likely to impair classification of the radiograph for pneumoconiosis." (DX 21).

existence of total disability which include the results of pulmonary function studies and arterial blood gas studies.

The record contains numerous pulmonary function studies conducted on February 2, 2004 (DX 18), August 31, 2004 (EX 1), January 25, 2005 (CX 1), September 14, 2005 (CX 4), and November 7, 2005 (EX 7). Although several physicians found that the studies revealed some abnormality, none of the studies (before or after bronchodilator) are qualifying under the regulatory standards set forth in 20 C.F.R. Part 718, Appendix B. In view of the foregoing, I find that the pulmonary function study evidence does not clearly establish the presence of a total disabling pulmonary or respiratory impairment.

C. Arterial Blood Gas Studies

Blood gas studies are performed to detect an impairment in the process of alveolar gas exchange. This defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise.

The record includes arterial blood gas studies which were administered on February 2, 2004 (DX 16) and November 7, 2005 (EX 7). On both occasions, the studies were administered at rest and exercise. Although all of the blood gas studies (resting and exercise) were abnormal, only the exercise study, dated February 2, 2004, yielded qualifying values under the criteria stated in 20 C.F.R. Part 718, Appendix C. However, Dr. Pickerill reported that the exercise study on November 7, 2005 "was stopped after 7 ½ minutes on a cycle ergometer at 80 watts because of shortness of breath and fatigue" (EX 7). Therefore, the only *completed* exercise blood gas test (*i.e.,* the February 2, 2004 study) is qualifying. As stated above, Claimant's last usual coal mine job entailed significant manual labor. Accordingly, I find that the completed exercise study is more probative than the resting and/or incomplete exercise arterial blood gases. In view of the foregoing, I find that the arterial blood gas evidence supports a finding of total disability.

D. Physicians' Opinions (including CT scan Interpretations)

The record contains a descriptive interpretation by Dr. Thomas M. Hayes, dated December 20, 2005, of a CT examination of the thorax dated February 21, 2005 (EX 9). In summary, Dr. Hayes stated:

> **IMPRESSION:** There are no parenchymal changes to suggest occupational pneumoconiosis of any type. Specifically, I seen no small rounded or small irregular opacities, and no nodular fibrosis. There are calcified granulomas as per above. Otherwise the CT examination is normal, with the exception of vascular calcifications.

(EX 9). As stated above, Dr. Hayes is a dual-qualified B-reader and Board-certified radiologist (DX 22).

Dr. Shyam Gohel issued a report, dated February 8, 2006, in which he stated, in pertinent part:

> [T]he patient's CT scan of 02-21-05 was reviewed, it is not possible to assess for pneumoconiosis on this CT scan as it was not performed utilizing a high resolution protocol which would be required to delineate fine interstitial nodular changes.

(CX 9). As stated above, Dr. Gohel is a dual-qualified B-reader and Board-certified radiologist (DX 22).

In summary, Dr. Hayes interpreted the CT scan as negative for pneumoconiosis, while Dr. Gohel opined that the CT scan evidence is unhelpful in diagnosing pneumoconiosis, because it did not use a high resolution protocol. In either case, the CT scan evidence does not affirmatively establish the presence of pneumoconiosis. Moreover, as stated above, the x-ray evidence neither precludes nor establishes the existence of pneumoconiosis. Accordingly, I find that the overall radiological evidence (*i.e.,* x-ray and CT scan combined) is, at best, inconclusive regarding the presence or absence of pneumoconiosis.

The other relevant medical opinion evidence consists of the reports and/or deposition testimony of Drs. Celko (DX 15; EX 5), Cohen (CX 1; EX 11), Bobak (CX 6; EX 12), Fino (EX 1, 6), and Pickerill (EX 7, 13), who addressed the issues of (clinical and legal) pneumoconiosis, total disability, and/or disability causation.

Dr. David A. Celko, who is Board-certified in Internal Medicine (EX 5, pp. 3-5),[7] examined Claimant on February 9, 2004 (DX 15). On a U.S. Department of Labor form, Dr. Celko referred to an attachment regarding Claimant's coal mine employment history (DX 15, Sec. B). The attachment consists of an Employment History form, as well as a typewritten statement entitled "Ronald McCrae Employment History," which provided a detailed discussion of Claimant's coal mine and non-coal mine work history between 1964 and 1994. On the form report, Dr. Celko also set forth Claimant's family, medical, and social history. The latter included an ongoing cigarette smoking history of about one pack per day, beginning at age 9 (*i.e.,* 1949). (DX 15, Sec. C3). Dr. Celko also noted Claimant's complaint of dyspnea (DX 15, Sec. D1). Physical findings on examination of the thorax and lungs were normal (DX 15, Sec. 4). In addition, Dr. Celko discussed various clinical test results obtained in February, 2004, as follows:

	Summary of Results
Chest X-ray:	Old granulomatous lung disease.
	No evidence of pneumoconiosis.
Vent Study (PFS)	Severe reduction DLCO
	Moderate obstructive vent pattern, Excellent BD response.
Arterial Blood Gas	
Resting	Hypercarbia & Hypoxemia
Exercise	exercise profound hypoxemia
Other: ECG	Sinus Bradycardia occas. PVC

[7] The District Director's office listed Dr. Celko's qualifications as follows: "Board-certified in Internal Medicine, Subspecialty in Pulmonary Disease" (DX 36). However, in his deposition testimony, Dr. Celko expressly stated that he is *not* Board-certified in the subspecialty of pulmonary medicine (EX 5, p. 5).

(DX 15, Sec. D5).

Under the Cardiopulmonary Diagnoses section of the U.S. Department of Labor form report, Dr. Celko stated: "(a) COPD/Chronic respiratory failure; (b) Obstructive sleep apnea." Dr. Celko did not provide the bases for these diagnoses as requested on the form report (DX 15, Sec. D6). Dr. Celko did not specify the etiology of Claimant's obstructive sleep apnea. However, he reported the etiology of Claimant's COPD/Chronic respiratory failure as follows: "cigarette smoking &/or occupational dust exposure." Dr. Celko failed to provide the rationale for this finding, as requested on the form report (DX (DX 15, Sec. D7). When asked the severity of Claimant's impairment from a chronic respiratory or pulmonary disease, if any, Dr. Celko stated: "totally disabled from pulmonary standpoint cigarette smoking &/or occupational dust exposures (chronically) contribute to PFT abnormalities & symptoms (DX 15, Sec. D8a). When asked the extent to which each of the diagnosed conditions contributes to Claimant's impairment, Dr. Celko simply stated: "totally disabled from COPD/chronic respiratory failure" (DX 15, Sec. D8b).

On January 31, 2005, Dr. Celko testified at deposition (EX 5). Although Claimant testified that Dr. Celko had been treating him for breathing problems since 1995 (TR 33-34), Dr. Celko simply stated that he examined Claimant at the request of the Department of Labor on February 9, 2004 (EX 5, p. 5). Dr. Celko reiterated most of the conclusions which he had set forth in written report. Furthermore, he provided a reasoned explanation for his diagnoses of chronic obstructive lung disease with chronic respiratory failure and obstructive sleep apnea (EX 5, pp. 5-11). However, I find that Dr. Celko's opinion regarding the role of Claimant's coal mine dust exposure in causing the chronic obstructive lung disease and/or total disability is ambiguous, conflicting and poorly reasoned. For example, Dr. Celko stated, in pertinent part: "I could not exclude occupational exposure as an etiology for that chronic obstructive lung disease." (EX 5, p. 11). Although this statement does not represent an affirmative finding that Claimant's respiratory or pulmonary impairment is significantly related to, or substantially aggravated by dust exposure in coal mine employment, Dr. Celko also testified that pneumoconiosis was a "substantial" contributing factor in Claimant's disability (EX 5, p. 14). If credited, this would support a finding of "legal pneumoconiosis" and "total disability due to pneumoconiosis." However, Dr. Celko repeatedly stated that he could not separate out the effects of cigarette smoking from coal dust exposure when looking at the cause of Claimant's impairment (EX 5, pp. 12, 14, 15, 30-31). Since Dr. Celko could not make a distinction between the effects of cigarette smoking and coal mine dust exposure, this undermines his assertion that coal mine dust exposure played a "substantial" contributing role in Claimant's total disability. Furthermore, Dr. Celko acknowledged that the normal lung volumes rule out the presence of a significant fibrotic disease, such as pneumoconiosis (EX 5, p. 27); and, that, assuming Claimant had not worked in the coal mines, Claimant's cigarette smoking history alone is sufficient to render him totally disabled (EX 5, pp. 26-29).

Dr. Robert A.C. Cohen, a B-reader who is Board-certified in Internal Medicine, Critical Care Medicine, and Pulmonary Disease, examined Claimant on January 25, 2005 (CX 1). In a report, dated March 14, 2005, Dr. Cohen set forth an 23-year coal mine employment history. He

also discussed the history of Claimant's present illness, including shortness of breath and related problems. Under "Social History," Dr. Cohen reported a smoking history which began in the mid-teens, stopped for 7 years, and, then resumed. Claimant reportedly smoked between ½ and 2 packs per day, and had cut back to ½ pack per day one month earlier. Dr. Cohen stated: "I will assume he smoked from one to 2 packs per day for a history of 45-90 pack years." In addition, Dr. Cohen set forth Claimant's occupational history ending in 1994, normal findings on physical examination of the lungs, his own positive x-ray finding of pneumoconiosis, and the results of other clinical tests which he administered. In addition, Dr. Cohen summarized some other medical evidence, such as Dr. Celko's opinion, conflicting x-ray readings, other pulmonary function study and arterial blood gas test results, and a cursory, summary of treatment records from Monogahel Valley Hospital, in March 2002, which listed various non-pulmonary discharge diagnoses (CX 1, Dr Cohen report, pp. 1-7). In support of his finding that Claimant suffers from coal worker's pneumoconiosis, Dr. Cohen cited the following: a 23-year, underground coal mine employment history with "extremely heavy coal mine dust exposure;" subjective complaints of symptoms consistent with chronic lung disease; pulmonary function tests showing mild obstruction with severe diffusion impairment and abnormal arterial blood gases which worsen with exercise consistent with Claimant's coal mine employment and cigarette smoking histories; and, "significant" positive x-ray evidence for coal worker's pneumoconiosis. However, Dr. Cohen also noted that if the overall x-ray evidence were interpreted as negative, it would not change his opinion that Claimant has clinical and physiological evidence of pneumoconiosis related to coal dust exposure (CX 1, Dr Cohen report, pp. 7-8). In addition, Dr. Cohen cited medical literature to support the conclusion that coal dust causes obstructive lung disease, such as the totally disabling pulmonary impairment evidenced by Claimant's pulmonary function results (CX 1, Dr. Cohen report, pp. 8-11). In summary, Dr. Cohen stated:

> **Conclusion**
> The sum of the medical evidence in conjunction with this patient's work history indicates that this patient's 23 years of coal mine dust exposure and his 45 to 90 pack years of exposure to tobacco smoke was (sic) significantly contributory to the development of his moderate obstructive lung disease and hypoxemia on resting arterial blood gases. This degree of impairment is clearly disabling for the duties of his last coal mining job as a mechanic.

(CX 1, Dr. Cohen report, p. 11).

On January 26, 2006, Dr. Cohen testified at deposition (EX 11). Regarding the underlying bases for his diagnosis of coal worker's pneumoconiosis, Dr. Cohen stated, in pertinent part: a reduction in Claimant's coal mine employment history from 23 years to 19.9 years "probably would not change (his) conclusions;" a history of coal mine employment alone does not mean that a person has coal worker's pneumoconiosis; the symptoms cited by Claimant are not etiologic of coal worker's pneumoconiosis; the types of impairment shown on pulmonary function testing and arterial blood gas studies are nonspecific and can be seen in individuals who have never been exposed to coal mine dust; and, even though the positive x-ray reading constitutes significant evidence for coal worker's pneumoconiosis, in the absence of any other occupational exposure, he would reach the same conclusion even if the x-ray evidence were

negative for pneumoconiosis (EX 11, pp. 21-25). Dr. Cohen's opinion is summarized in the following statement:

> His entire physiologic findings could certainly be compatible with tobacco exposure alone, absent the chest x-ray as you mentioned, as could his entire physiologic findings be attributed to his coal dust exposure alone absent cigarette smoking. But this man has both exposures. That's why I attributed it to both of them.

(EX 11, p. 27). Furthermore, Dr. Cohen testified that there are no specific tests which he is aware of to differentiate between the two exposures which cause "a very, very similar impairment." Accordingly, Dr. Cohen stated that he relies on epidemiologic evidence of both these exposures (EX 11, pp. 27-28). Dr. Cohen stated that studies showed, in post-1970 coal mining, an equivalency between "half-pack year of tobacco smoke exposure reduction in FEV-1 per year of underground mining." (EX 11, p. 28). Based upon a post-1970, coal mine employment history of 23 years, Dr. Cohen found "at least a ten-year equivalency." Depending on Claimant's actual cigarette smoking history, Dr. Cohen estimated that Claimant's cigarette smoking causes roughly 75% to 90% of his impairment. The remaining 10% to 25% was attributed to Claimant's coal mine dust exposure (EX 11, pp. 29-39). In any event, Dr. Cohen stated that "coal mine dust exposure was significantly contributory." (EX 11, p. 28). On the other hand, Dr. Cohen acknowledged that, if Claimant had not been a coal miner, he would have attributed Claimant's impairment solely to tobacco smoke (EX 11, p. 31). Moreover, Dr. Cohen reiterated that there is no specific test or technology available to apportion between the two exposures, where the two exposures cause the same disease (EX 11, p. 56). Finally, Dr. Cohen stated that, he attributed Claimant's impairment to both cigarette smoking and coal mine dust, because Claimant had both exposures. However, Dr. Cohen also acknowledged that Claimant could have had the exact same impairment and disability had he never been in the coal mines (EX 11, p. 60).

Dr. Walter Bobak issued an undated, "To Whom It May Concern" letter, "in support of my patient Ronald McCrae" (CX 6). The latest clinical test results cited therein is dated September 14, 2005. Accordingly, I surmise that the undated letter was prepared after that date. In the undated letter, Dr. Bobak stated that he has been "treating Mr. McCrae for about 15 years." (CX 6). This would suggest that Dr. Bobak began treating Claimant in or about 1990. However, in deposition testimony, Dr. Bobak subsequently stated that he actually began treating Claimant in March of 1987 (EX 12, pp. 20-21). Dr. Bobak is Board-certified in Internal Medicine. However, he is neither Board-certified nor Board-eligible in pulmonary medicine. Furthermore, Dr. Bobak acknowledged that he does not hold himself out as a pulmonary expert (EX 12, pp. 10-12). In the undated letter, Dr. Bobak reported severe oxygen desaturation as shown on exercise arterial blood gas test on February 9, 2004, and documented again on subsequent tests. Based upon the foregoing, Dr. Bobak opined that Claimant "has a totally disabling pulmonary impairment which would preclude him from doing the exertional work of a coal miner." In addition, Dr. Bobak cited Claimant's 20 years of underground coal mine work and positive x-ray readings of pneumoconiosis, as well as Claimant's "many years of smoking." Moreover, Dr. Bobak stated that he has been treating Claimant "for a breathing impairment with the assistance of Dr. David Celko, a Pulmonologist," and cited various medications and supplemental oxygen at night. In summary, Dr. Bobak stated:

> In conclusion, I restate my opinion that Mr. McCrae's breathing impairment is the result of both his Coal Workers' Pneumoconiosis and his multiple pack year smoking history. Th (sic) pulmonary impairment is totally disabling in terms of further heavy, dusty work as an underground coal miner.

(CX 6).

On February 8, 2006, Dr. Bobak testified at deposition (EX 12). Dr. Bobak acknowledged that he did not mention coal worker's pneumoconiosis until January 9, 2004, even though he had treated Claimant since March of 1987 (EX 12, pp. 21-22). Dr. Bobak denied that he based his diagnosis on two positive x-ray interpretations. To the contrary, he testified that the diagnosis is based upon Claimant's work history and oxygen desaturation during minor exercise (EX 12, p. 32). On the other hand, Dr. Bobak acknowledged that he did not think it is medically feasible to distinguish between impairment due to cigarette versus impairment due to coal dust, and that he was not attempting to do so (EX 12, pp. 45, 71). Moreover, Dr. Bobak clarified his written statement, and testified that he did not treat Claimant for a pulmonary problem, but rather that Dr. Celko did so (EX 12, p. 27). Furthermore, I find that Dr. Bobak's deposition testimony indicates a lack of expertise in pulmonary medicine, and, in analyzing pneumoconiosis from a radiological and/or pulmonary function study standpoint. On the other hand, Dr. Bobak indicated somewhat greater familiarity with blood gases (EX 11, pp. 12-20).

Dr. Gregory J. Fino, a B-reader who is Board-certified in Internal Medicine and Pulmonary Disease (EX 1), examined Claimant on August 31, 2004. In a report, dated September 24, 2004 (EX 1), Dr. Fino set forth Claimant's patient profile, occupational history, symptoms, past medical history, family history, review of systems, findings on physical examination, and the results of various clinical studies. In addition, Dr. Fino reviewed other additional evidence, and set forth a flow sheet of chest x-rays, pulmonary function studies, arterial blood gases, and reported occupational and smoking histories. In summary, Dr. Fino stated:

> **Diagnosis**
>
> Moderately severe obstructive lung disease with emphysema and chronic obstructive bronchitis all consistent with cigarette smoking.
>
> **Discussion**
>
> The above information has been reviewed, and it is my opinion that this man does not suffer from coal workers' pneumoconiosis based on the following:
>
> 1. All of the chest x-ray readings are negative for pneumoconiosis.
>
> 2. My reading of the chest x-ray is negative for pneumoconiosis.
>
> 3. The obstructive abnormality is consistent with cigarette smoking.

4. The reduction in diffusion is consistent with emphysema.

5. The drop in the pO2 with exercise correlates with this man's significant emphysema.

6. The TLC was not reduced and this rules out the presence of restrictive lung disease and significant pulmonary fibrosis.

From a functional standpoint, this man's pulmonary system is abnormal. He does not retain the physiologic capacity, from a respiratory standpoint, to perform all of the requirements of his last job. There are two risk factors for this disability – coal mine dust exposure and cigarette smoking. In this instance, the clinical information is consistent with a smoking-related disability. Even if chronic obstructive lung disease due to coal mine employment contributed to the obstruction, the loss in the FEV1 would be in the 200 cc range. If we gave back to him that amount of FEV1, this man would still be disabled. This medical estimate of loss in the FEV1 in working miners was summarized in the 1995 NIOSH document. Although a statistical drop in the FEV1 was noted in working miners, that drop was not clinically significant. This man would be as disabled had he never stepped foot in the mines.

Conclusions

1. There is insufficient objective medical evidence to justify a diagnosis of coal workers' pneumoconiosis.

2. There is a disabling respiratory impairment present due to cigarette smoking.

3. From a respiratory standpoint, this man is disabled from returning to his last mining job or a job requiring similar effort.

4. Even if I were to assume that this man has coal workers' pneumoconiosis, it has not contributed to his disability. He would be as disabled had he never stepped foot in the mines.

(EX 1, pp. 7-8).

In his deposition testimony on November 9, 2005, Dr. Fino reiterated that, although Claimant is disabled by lung disease, the disability is due to cigarette smoking, not coal dust exposure (EX 6, pp. 20-21). In excluding a coal mine dust-related condition, Dr. Fino cited negative x-ray evidence among various reasons, but noted that one can still have pneumoconiosis notwithstanding a negative chest x-ray (EX 6, p. 14). In addition, Dr. Fino cited the reversibility which is more consistent with a smoking-related abnormality than a coal mine dust-related disease. Moreover, Dr. Fino cited medical literature which establishes that the potential loss due to coal mine dust exposure is not clinically significant. Furthermore, Dr. Fino cited another medical study which establishes a correlation between the amount of coal dust in the lungs, as

shown radiographically or pathologically, and the extent that coal mine dust contributes to the development of emphysema. In view of the foregoing, Dr. Fino stated that, even assuming the accuracy of the positive (1/1) interpretations, he would still not find that pneumoconiosis and/or coal mine dust exposure played a clinically significant role in causing miner's impairment and/or disability (EX 6, pp. 14-21).

Dr. Robert G. Pickerill, a B-reader who is Board-certified in Internal Medicine, Pulmonary Diseases, and Critical Care Medicine (EX 13, p. 8), examined Claimant on November 7, 2005 (EX 7). In his report on that date, Dr. Pickerill set forth a 23-year history in the underground coal mining industry, as well as Claimant's occupational history, generally, through 1995. Dr. Pickerill also reported an understated cigarette smoking history of only 12-14 cigarettes for about 40 years, ending "about 3-4 weeks ago." Dr. Pickerill also reported Claimant's symptoms, a list of medications, allergies, past medical history, and family history. Physical findings on examination of the lungs were normal. Dr. Pickerill also discussed findings on various clinical tests, including pulmonary function studies, arterial blood gases, electrocardiogram, and chest x-rays. In addition, Dr. Pickerill reviewed other available medical records, including the opinions of Drs. Celko, Fino, Bobak, and, records from Monongahala Hospital. Furthermore, Dr. Pickerill also charted his review of various chest x-rays, pulmonary function tests, arterial blood gases, and electrocardiograms. In summary, Dr. Pickerill stated:

> DIAGNOSES:
>
> 1. Moderate chronic obstructive pulmonary disease (COPD) and pulmonary emphysema due to previous tobacco smoking.
> 2. Chronic pulmonary granulomatous disease with calcified granuloma in the right lung and calcified hilar and mediastinal lymph nodes.
> 3. History of obstructive sleep apnea treated with CPAP and nocturnal oxygen.
> 4. Coronary artery disease.
>
> ASSESSMENT:
> It is my opinion with a reasonable degree of medical certainty that Mr. Ronald McCrae has a significant functional respiratory impairment, which I would attribute to chronic obstructive pulmonary disease (COPD) and pulmonary emphysema due to previous tobacco smoking.
>
> The abnormal chest x-rays are more consistent with chronic granulomatous disease from a previous infection such as histoplasmosis rather than coal workers' pneumoconiosis.
>
> I cannot completely exclude the possibility that coal dust exposure has contributed to his lung disease.
>
> However, it is my opinion with a reasonable degree of medical certainty that his obstructive lung disease is primarily due to tobacco smoking.
>
> It is also my opinion with a reasonable degree of medical certainty that he would not be able to do his last job in the coal mining industry from a respiratory standpoint, but coal dust exposure would only have a minor contribution to his overall lung disease.

(EX 7).

In his deposition testimony on February 14, 2006, Dr. Pickerill further explained his opinion (EX 13). He noted that the higher smoking histories reported by other physicians buttress his opinion that the Claimant's COPD is related to tobacco smoking (EX 13, p. 23). Dr. Pickerill explained that he could not completely exclude the possibility that coal dust exposure also contributed to Claimant's lung disease, because it is possible that the calcified granulomas and calcified lymph nodes could be attributed to dust exposure, even though it is more typically attributed to a previous granulomas infection such as histoplasmosis. Thus, Dr. Pickerill stated that if, by biopsy or other means, it was established that these abnormalities were due to coal dust, he would revise his opinion. However, in the absence of such evidence, Dr. Pickerill stated, in pertinent part: "I have no objective evidence that could cause me to diagnose coal worker's pneumoconiosis within a reasonable degree of medical certainty at this time. I would have to attribute the abnormal chest x-rays due to chronic granulomatous disease." (EX 13, pp. 23-24). Moreover, Dr. Pickerill reiterated that the Claimant's COPD is significantly related to tobacco smoking. While Dr. Pickerill could not completely exclude a minor contribution from coal dust exposure based strictly upon Claimant's history, he could not cite any objective findings to support such a causal connection. Furthermore, Dr. Pickerill stated that, he "would not be able to attribute a substantial cause or contribution from coal dust exposure with a reasonable degree of medical certainty" (EX 13, pp. 24-25). In summary, Dr. Pickerill reiterated that Claimant's moderate functional respiratory impairment would most likely prevent him from performing the activities required in his previous coal mine employment. However, he attributed the underlying obstructive lung disease primarily to tobacco smoking, while stating that he could not state, with a reasonable degree of medical certainty, that coal dust exposure had a material adverse affect on Claimant's condition (EX 13, pp. 29-31).

Pneumoconiosis

Section 718.202 provides four means by which pneumoconiosis may be established. Under §718.202(a)(1), a finding of pneumoconiosis may be made on the basis of the x-ray evidence. As stated above, the record contains multiple positive and negative interpretations by similarly well-qualified B-readers and/or Board-certified radiologists. Accordingly, the x-ray evidence neither precludes nor establishes the presence of pneumoconiosis. Therefore, Claimant has failed to meet his burden of establishing the existence of pneumoconiosis under §718.202(a)(1).

Under §718.202(a)(2), a finding of pneumoconiosis may be made on the basis of biopsy or autopsy evidence. In the absence of any such evidence, this subsection is not applicable.

Section 718.202(a)(3) provides that pneumoconiosis may be established if any one of several cited presumptions are found applicable. In the instant case, the presumption of §718.304 does not apply because there is no evidence in the record of complicated pneumoconiosis. Section 718.305 is inapplicable to claims filed after January 1, 1982. Finally, the presumption of §718.306 does not apply to living miner's claims. Therefore, the Claimant cannot establish pneumoconiosis under §718.202(a)(3).

Under §718.202(a)(4), a determination of the existence of pneumoconiosis may be made if a physician exercising reasoned medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in §718.201. Pneumoconiosis is defined in §718.201 means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both "Clinical Pneumoconiosis" and "Legal Pneumoconiosis." *See* 20 C.F.R. §718.202(a)(1) and (2).

As stated above, the CT scan interpretation by Dr. Hayes is negative for pneumoconiosis. However, Dr. Gohel opined that the CT scan evidence is not particularly useful in this case, because it did not use a high resolution protocol. Both physicians are dual-qualified B-readers and Board-certified radiologists. In view of the foregoing, the CT scan evidence clearly does not establish the presence of pneumoconiosis. At best, the negative CT scan interpretation is not probative. However, the crux of this cases rests on the etiology of Claimant's total pulmonary disability, since this addresses the issues of (legal) pneumoconiosis and disability causation.

As summarized above, Drs. Celko (DX 15; EX 5), Cohen (CX 1; EX 11), Bobak (CX 6; EX 12), Fino (EX 1, 6), and Pickerill (EX 7, 13) each provided opinions regarding these issues. As fact-finder, I must conduct a qualitative assessment of the conflicting medical opinion evidence by analyzing the credibility of each medical opinion considered as a whole, in light of that physician's credentials, documentation, and reasoning. As stated above, Drs. Celko and Bobak are Board-certified in Internal Medicine. However, they are not Board-certified in Pulmonary Disease. In contrast, Drs. Cohen, Fino, and Pickerill are all Board-certified pulmonary specialists. Although Dr. Celko reportedly has treated Claimant for his pulmonary condition, his analysis focuses upon his U.S. Department of Labor examination of Claimant on February 9, 2004. Dr. Celko failed to describe how his treatment of Claimant helped him render his opinion. Therefore, I find that Dr. Celko's status as a treating physician is not significant. Similarly, the testimony of Claimant and Dr. Bobak establishes that the latter had minimal, if any, involvement in the treatment of Claimant's pulmonary condition. Accordingly, I find that Dr. Bobak's status as a treating physician is also inconsequential. Furthermore, I find that Drs. Celko and Bobak not only lack the pulmonary qualifications of Drs. Cohen, Fino, and Pickerill, but also that the opinions of Drs. Celko and Bobak are not as well-reasoned and/or documented as those of the other physicians. In view of the foregoing, I accord the opinions of Drs. Celko and Bobak less weight.

In evaluating the medical opinions of the Board-certified pulmonary specialists, I find that Drs. Cohen, Fino, and Pickerill all agree that Claimant suffers from a totally disabling pulmonary or respiratory impairment which is, at least, primarily due to Claimant's extensive cigarette smoking history. This consensus opinion is credible, in view of the abnormal clinical test results, the manual labor entailed in Claimant's last usual coal mine job, and Claimant's very significant cigarette smoking history. Moreover, I find that Claimant's actual cigarette smoking, which began at age 9 (*i.e.,* 1949) and *possibly* ended in October 2005, dwarfs Claimant's coal mine employment history of 19.99 years ending in 1995. Therefore, the crux of this case rests on the role of Claimant's coal mine dust exposure, if any, in contributing to Claimant's impairment and disability.

In summary, Dr. Cohen estimated that coal mine dust exposure is a 10% to 25% contributing factor in Claimant's impairment or disability. Dr. Fino opined that coal mine dust exposure is a non-factor, and, that the medical literature establishes that any potential loss due to coal mine dust exposure is not clinically significant. Finally, Dr. Pickerill stated that, although he could not completely exclude a minor contribution from coal dust exposure based strictly upon Claimant's history, there were no objective findings to support such a causal connection. Therefore, Dr. Pickerill could not attribute a substantial cause or contribution from coal dust exposure.

Having carefully considered the medical opinion evidence of the pulmonary specialists, I find that the opinions of Drs. Cohen, Fino, and Pickerill are all well-reasoned and documented. However, even Dr. Cohen acknowledged that Claimant could have had the exact same impairment and disability had he never been in the coal mines (EX 11, p. 60). Taken as a whole, I find that the credible medical opinion evidence establishes that Claimant suffers from a total pulmonary disability attributable primarily, if not exclusively, to cigarette smoking; and, that the role of coal mine dust exposure, if any, is clinically insignificant. Accordingly, I find that Claimant has failed to establish pneumoconiosis under §718.202(a)(4).

I have also weighed all the relevant evidence together under 20 C.F.R. §718.202(a) to determine whether the miner suffered from pneumoconiosis, as defined in §718.201. In summary, I find that the x-ray evidence is inconclusive, and, that the medical opinion evidence (including the CT scan evidence) fails to establish (clinical or legal) pneumoconiosis. Therefore, taken as whole, I find that pneumoconiosis has not been established under 20 C.F.R. §718.202(a). *See, Penn Allegheny Coal Co. v. Williams,* 114 F. 3d 22 (3d Cir. 1997); *Island Creek Coal Co. v. Compton*, 211 F. 3d 203, 2000 WL 524798 (4th Cir. 2000).

Causal Relationship

Since Claimant has failed to establish the presence of (clinical or legal) pneumoconiosis, he also cannot establish that the disease arose from his coal mine employment. If Claimant had established the existence of pneumoconiosis, however, he would be entitled to the rebuttable presumption that the disease arose from his more than ten years of coal mine employment. 20 C.F.R. §718.203. However, in order to be eligible for benefits, Claimant still must establish that he suffers from a totally disabling pulmonary or respiratory impairment, and that such total disability is due to pneumoconiosis.

Total Disability

The regulations provide that a claimant can establish total disability by showing the miner has a pulmonary or respiratory impairment which, standing alone, prevents the miner from performing his or her usual coal mine work, and from engaging in gainful employment in the immediate area of his or her residence requiring the skills or abilities comparable to those of any employment in a mine or mines in which he or she previously engaged with some regularity over a substantial period of time. *See* 20 C.F.R. §718.204(b)(1). Where, as here, complicated pneumoconiosis is not established, total disability may be established by pulmonary function tests, by arterial blood gas tests, by evidence of cor pulmonale with right-sided congestive heart

failure, or by physicians' reasoned medical opinions, based upon medically acceptable clinical and laboratory diagnostic techniques, that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in his usual coal mine work or comparable employment. *See* 20 C.F.R. §718.204(b)(2)(i)-(iv).

As outlined above, although the results of the pulmonary function studies are abnormal, none of the tests are qualifying under the regulatory standards set forth in 20 C.F.R. Part 718, Appendix B. Therefore, I find that Claimant has not established total disability pursuant to §718.204(b)(2)(i).

As stated above, the majority of the arterial blood gas studies are not qualifying under the applicable standards stated in Part 718, Appendix C. However, the only completed exercise blood gas test, dated February 2, 204, is qualifying. In view of the arduous nature of Claimant's last usual coal mine work, I accord this exercise study the most weight. Therefore, I find that Claimant has established total disability pursuant to §718.204(b)(2)(ii).

Since there is no evidence which establishes the presence of cor pulmonale with right-sided heart failure, Claimant cannot establish total disability pursuant §718.204(b)(2)(iii).

Under §718.204(b)(2)(iv), total disability may also be found if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner respiratory or pulmonary condition prevented the miner from engaging in his usual coal mine work or comparable and gainful work.

As summarized above, there is a consensus among the physicians, including all of the pulmonary specialists, that Claimant suffers from a totally disabling respiratory impairment. Accordingly, Claimant has clearly established total disability under §718.204(b)(2)(iv).

Having weighed all of the relevant evidence, like and unlike, I find that, notwithstanding the nonqualifying pulmonary function studies and mixed arterial blood gas results, the medical opinion evidence, in conjunction with the physical exertion required in Claimant's last usual coal mine job, establishes that Claimant suffers from a totally disabling pulmonary or respiratory impairment. Accordingly, I find that, taken as a whole, Claimant has established total disability under §718.204(b).

Total Disability Due to Pneumoconiosis

Pneumoconiosis is a "substantially contributing cause" of the miner's disability if it:

(i) Has a material adverse effect on the miner's respiratory or pulmonary condition; or
(ii) Materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease unrelated to coal mine employment.

20 C.F.R. §718.204(c).

For the reasons outlined above, I find that Claimant did not establish total disability due to pneumoconiosis under §718.204(c).

Conclusion

The record fails to establish (clinical or legal) pneumoconiosis. Furthermore, although Claimant suffers from a totally disabling pulmonary or respiratory impairment, the evidence does not establish that pneumoconiosis is a substantially contributing cause of Claimant's total disability. In view of the foregoing, I find that the Claimant is not entitled to benefits under the Act and applicable regulations.

Attorney's Fees

The award of an attorney's fee under the Act is permitted only in the cases in which Claimant is found to be entitled to benefits. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the claimant for services rendered to him in pursuit of this claim.

ORDER

It is ordered that the claim of Ronald McCrae for benefits under the Black Lung Benefits Act is hereby **DENIED.**

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RICHARD A. MORGAN
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with this Decision and Order you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which this Decision and Order is filed with the district director's office. *See* 20 C.F.R. §§725.458 and 725.459. The address of the Board is: ***Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, D.C. 20013-7601.*** Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. §802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor for Black Lung and Longshore Legal Services, U.S.

Department of Labor, 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C. 20210. *See* 20 C.F.R. §725.481.

If an appeal is not timely filed with the Board, this Decision and Order will become the final order of the Secretary of Labor pursuant to 20 C.F.R. §725.479(a).